

RECOVERING HEALTH CARE IN POST-KATRINA NEW ORLEANS

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ABSTRACT

MOLLY DAVIS: Recovering Health Care in Post-Katrina New Orleans

(Under the direction of Tom Linden)

This thesis describes the Louisiana health care system. The literature review is a case study of the New Orleans health care sector, previous to and after Hurricane Katrina. The review examines criticism of the system, particularly criticisms of the public hospital system, the Medicaid disproportionate share hospital reimbursement fund, the low rate of insurance coverage among Louisiana residents and the barriers to health care in New Orleans' indigent population. The main body of the thesis is a series of journalistic articles. The first article is an overview of the system and the proposed "dollar follow the patient" reform. The second two articles are narratives, the first based on a provider and the second on a patient. The conclusion supports reform of Louisiana's health care funding and payment system, in order to bring health care coverage closer to a universal level, alleviate the burden of an under-funded hospital system and create a healthier population in the long term.

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CHAPTER I: INTRODUCTION

This thesis addresses many documented criticisms of the pre-Katrina Louisiana health care system, in particular the effects of these state-wide problems in the city of New Orleans. The thesis also discusses how that system reached certain populations, such as federal prisoners, that no other provider reaches. The pre-Katrina Charity Hospital, in particular, provided the highest quality of care available in the region for trauma victims. This thesis will not ignore, however, the abundant criticism of Louisiana health care financial policy that exists in the public health literature. This project will illustrate both the positive and negative side of the Louisiana health care system.

Theoretical Justification

Rudowitz, Rowland and Shartzter (2006) argue that Louisiana's use of public funds perpetuated the state's reliance on inpatient care for low-income residents. Medicaid spending supported the delivery of a group of vital emergent and acute services to the community while simultaneously limiting the availability of non-emergent care. Charity Hospital in New Orleans held this unbalanced safety-net system together.

Many other aspects of municipal life in New Orleans are still in recovery from Hurricane Katrina. The health care system, however, was under-funded, mismanaged and ripe for reform before the storm ever hit. It is more important than ever, and some say more *possible* than ever, to examine these issues and adapt policy accordingly.

CHAPTER II: LITERATURE REVIEW

New Orleans has a rich history of immigration and diversity, both of which have influenced the shape of the city and its health care system. The Spanish colonists first arrived in New Orleans in 1500, then came French trappers and Acadians from present-day Canada, and by the end of the 1700s the slave trade had brought Africans to the area (Fletcher et al. 2006). The mid-1800s brought German immigrants, who were followed by Irish refugees from the potato famine. After the Civil War, Italians immigrated to the city, attracted by work opportunities opened up by the emancipation of the slaves.

The town has expanded outward from the French Quarter area, which borders the Mississippi River, onto progressively lower, marshier land. By the time the levees were constructed, most of New Orleans was located under the surface of neighboring bodies of water (Public health response 2006). This made the city extremely vulnerable to storms and floods. Meanwhile, the city has endured a history of violent crimes (including duels and drug-trafficking), periodic viral epidemics and the occasional massive fire. These adverse public health events have challenged the system throughout its evolution.

In one form or another, Charity Hospital has been part of the city's health care system for more than 250 years. A French sailor and boat-builder named Jean Louis had observed the military hospital turning away indigent patients. So, when Louis died on Jan. 21, 1736, in New Orleans, he bequeathed 10,000 French *livres* for the establishment of a new hospital to serve the poor.

The original Charity Hospital was founded “under conditions of desperate need” (Salvaggio 1992) and survived solely, at first, on private donations. Governor Huey Long expanded the Charity system in the early 20th century and helped to create the Louisiana State University (LSU) Medical School (Zigmond 2006). These two entities continue to be linked in one public hospital system known as the Medical Center of Louisiana. The Center operates five other medical centers in Louisiana.

The health care system before Katrina

Pre-Katrina, New Orleans was the center of population and commerce for Louisiana, as well as the center of the state’s public health infrastructure (Public health response 2006). The public hospitals that comprised New Orleans’ state-run safety net of health care carried most of the burden for providing care to low-income and uninsured individuals (Rudowitz, Rowland, and Shartzter 2006). There were many infrastructure improvements that needed funding in the years before the storm.

The Medical Center of Louisiana, a major part of the city’s safety-net health care system, included Charity and University Hospitals. By 2005, Charity Hospital alone accounted for more than 80 percent of both inpatient and outpatient costs to non-paying, uninsured patients in the greater New Orleans area. The occupancy rate at Charity was much higher than the average occupancy rate in the area (Rudowitz, Rowland, and Shartzter 2006).

In the first few years of the 21st century, Louisiana rated poorly on statewide quality of health care (Ellis 2006). According to a *Morbidity and Mortality Weekly Report* article published after the storm, Louisiana had the second-highest adult and

infant mortality rates in the country (Lambrew and Shalala 2006). By several standards, it was one of the unhealthiest states in the country.

Policymakers and researchers have often cited a lack of access to care as an explanation for the state's poor health record. Pre-Katrina, Louisiana had one of the highest uninsured rates in the country (Rudowitz, Rowland, and Shartzter 2006). One in five adults in Louisiana lacked health coverage. This rate amounted to almost 900,000 residents. Twenty-one percent of non-elderly residents in the state lacked health insurance, as opposed to 18 percent in the U.S.

The higher rate of uninsured residents could be partially explained by the presence of the city's abundant opportunities in non-traditional employment. There was a thriving music and art scene, a heavily service- and tourism-oriented economy and a high prevalence of small businesses, all of which are unlikely to offer employment-based coverage (Rudowitz, Rowland, and Shartzter 2006). Louisiana ranked second only to Texas in its uninsured rate; 23 percent of the population of Texas had enrolled in Medicaid (Ellis 2006).

About half of the patients at the Medical Center of Louisiana lacked health coverage, and about a third were enrolled in Medicaid (Zigmond 2006). With no funding mechanism in place to distribute public funds for uncompensated care to other community providers, the public hospitals played the difficult role of providing care to those patients in New Orleans with the greatest health care needs and the lowest incomes.

The pre-Katrina allocation of health care funds in New Orleans had created a two-tiered health care system, in which people with health insurance received a different level of care than individuals who lacked insurance (Greater New Orleans Health Planning

Group 2005). Only 6 percent of the care delivered at Charity Hospital went to patients with private health insurance, because insured patients generally chose to go elsewhere (Rudowitz, Rowland, and Shartzter 2006). The system resulted in one of the country's most over-crowded emergency systems. In 2004 Louisiana ranked fourth in the U.S. for emergency department use.

Brodie, Weltzien, Altman and others (2006) randomly surveyed a group of evacuees in Houston Red Cross shelters in September 2005 in order to document the *pre-Katrina* experiences of those hit hardest by the storm. By conducting interviews at shelters, the researchers targeted those residents who had previously relied on government help to evacuate and who did not currently have access to temporary housing. Many respondents had depended on care from a hospital or clinic, instead of a doctor's office.

Before the storm, black residents had a higher prevalence than whites of several chronic conditions, including heart disease, diabetes and asthma; and uninsured rates were significantly higher for blacks and Hispanics than for whites (Henry J. Kaiser Family Foundation 2006). This research underscores the significant racial disparities in health care and insurance coverage that existed in New Orleans before the storm. On multiple levels, New Orleans had a poor public health care system. Yet this system filled a gap that no other provider would fill, and it did so in perennial financial crisis.

The storm's devastation

On August 29, 2005, Hurricane Katrina made landfall on the Gulf Coast near the Mississippi-Louisiana border as a category 3 storm (Public health response 2006).

Winds experienced during the hurricane's earlier stage, when it had strengthened to a category 5 hurricane in the Gulf of Mexico, generated devastating storm surges for the coasts of Mississippi, Louisiana and Alabama.

Hurricane Katrina led to mortalities and massive migrations that created sudden and massive population shifts. According to a 2006 *Morbidity and Mortality Weekly Report*, approximately 1,000 people died as a result of Katrina in Louisiana alone, largely from storm surges and flooding (Public health response 2006). Katrina was the most deadly hurricane to strike the nation since 1928. More than 200,000 people evacuated to shelters around the country.

With damage estimated at more than \$80 billion, Katrina cost more than any natural disaster in the history of the U.S (Taylor et al. 2006). Tens of thousands of buildings sustained severe damage with the potential of causing chronic exposure-related health problems (Greater New Orleans Health Planning Group 2005).

The weather caused widespread damage to the health infrastructure as well. Facilities and technology were destroyed, and the workforce of medical providers was largely depleted (Zigmond 2006). The hurricane itself caused very little structural harm to the hospitals (Rodriguez, Trainor, and Quarantelli 2006). In fact, hospital workers expressed relief and optimism as the hurricane winds abated.

Less than 24 hours after landfall, however, levees in the Industrial Canal, 17th Street Canal and London Street Canal had broken, and flood waters expanded to cover more than 80 percent of New Orleans (Taylor et al. 2006). Stores of food, water and fuel were completely flooded. Communication systems failed, and telephone lines were undependable (Rodriguez et al. 2006). Hospital emergency generators ran out of fuel,

sewage systems broke down and diagnostic equipment malfunctioned in the heat. Public hospitals like Charity lacked the resources to arrange for security personnel and helicopters as quickly as private hospitals. After the storm, many structures in the city flooded and remained inundated with water for weeks. This created ideal conditions for mold growth (Brandt et al. 2006).

Hurricane Katrina and the resultant flood destroyed infrastructure and depleted the population. Only three hospitals stayed open through the hurricane (Rudowitz, Rowland, and Shartzter 2006). With city-wide health care disrupted, many residents with chronic conditions were forced to manage their health without treatments and often without basic utilities in their houses (Rudowitz, Rowland, and Shartzter 2006).

There is evidence that, from the moment that the storm winds subsided, members of different racial groups, income levels and health coverage status had very different displacement experiences. Among survey respondents who were evacuees in Houston shelters, people disproportionately identified themselves as black; had low incomes; did not have bank accounts, credit cards, transport, or savings; and had previously relied on care from Charity Hospital to manage chronic conditions (Rudowitz, Rowland, and Shartzter 2006). The population of evacuees in Houston was very similar to the population of uninsured people in the United States, except that Houston evacuees were much more likely to be black.

Charity Hospital opened a temporary emergency department in the Convention Center. In March 2006, Fletcher and others (2006) sampled New Orleans construction workers, targeting Latino workers in particular, to investigate human rights issues in the workforce in the Katrina-affected areas. The study found that the convention center-based

clinic was the only source of care for many individuals working in the aftermath of the storm. This group included a relatively new population of Latino workers, who frequently took risky construction-related jobs in flood-damaged environments during that period.

The political response

Legislation designed by the Bush Administration passed Congress with bipartisan support. The Emergency Health Care Relief Act, created in Katrina's aftermath, used Medicaid funds to issue waivers to enable evacuees to receive care wherever they were (Lambrew and Shalala 2006). The legislation, however, covered only those individuals already eligible for Medicaid. Low-income working males, in particular, who may have previously received services through the public health care system in New Orleans or lost their insurance as a result of the storm, were not eligible for the Medicaid waivers.

In a JAMA commentary, public health researchers Lambrew and Shalala argued that federal assistance post-Katrina was inadequate. The hospitals that had previously received the bulk of federal health care funds were almost entirely closed in the aftermath of the storm. Lambrew and Shalala posited that a more appropriate response would have been to funnel Medicaid's unspent hospital reimbursement funds into support for non-safety-net providers who were experiencing an increase in uninsured patients post-Katrina, or into an expansion of Medicaid coverage. Such coverage would include more enrollees than the traditional categories of eligibility in Louisiana allowed.

By the beginning of 2006, the nation had shifted its attention away from the Gulf Coast states' health problems, and yet federal funding continued to be critically important

(Lambrew and Shalala 2006). The cost of insurance premiums rose as access to providers shrank (Rudowitz, Rowland, and Shartzter 2006). In mid-July 2006 the bed capacity in Orleans Parish was still less than a quarter of the pre-Katrina amount. Emergency physicians in the Katrina-affected areas reported in August 2006 that emergency departments were slow to recover, and a large portion of emergency physicians were considering moving if progress was not made in the next year (Stephens 2006). In October 2006 the New Orleans health department was operating at about 20 percent of its pre-Katrina capacity. Hospital stays increased from 5.5 days on average before the hurricane to more than seven days, due to the lack of post-acute placement facilities.

Many residents of the greater New Orleans area have expressed support for a network of clinics based on neighborhood need (Lambrew and Shalala 2006). For some populations, community clinics are the only option. Fletcher and others (2006) demonstrated that, in the aftermath of the storm, undocumented workers had access to health care only through charity organizations and mobile clinics, and only if the care was free.

Policymakers now have the daunting task of rebuilding the New Orleans health care system in a way that relieves the burden on public hospitals and emergency departments. This goal is further complicated by uncertainty about the size and composition of the returning population (Rudowitz, Rowland, and Shartzter 2006). Researchers find it hard to predict how much of the new Latino population will stay in the area and how many pre-Katrina residents will return.

The personal costs of reconstruction

As with the process of clean-up after every major disaster, the reconstruction of New Orleans has exposed remediation workers to unhealthful, unsanitary and dangerous situations (Fletcher et al. 2006). How well leaders can avoid the overcrowding of emergency departments depends on the city's ability to prevent storm-related illnesses in the long term. Unfortunately, the most vulnerable workers are also those individuals who are least likely to have insurance or access to health care. Therefore they are least likely to have had their medical problems diagnosed accurately at an early stage.

Fletcher and others (2006) found that, among Latino construction workers in particular, documented and undocumented workers alike work in dangerous conditions, but undocumented workers are less likely to have been trained or equipped to prevent the health effects of their hazardous indoor work environments. Undocumented workers, predictably, are also much less likely to have access to primary care. Only about half of the documented construction workers in the Fletcher study had health insurance, and less than 9 percent of the undocumented workers did.

It was estimated that almost half of the homes in Orleans Parish and surrounding parishes suffered some level of mold contamination, and 17 percent of houses were heavily contaminated (Brandt et al. 2006). Proper remediation of affected buildings often includes structural repairs to prevent the entry of more water, removal of affected materials that can't be sufficiently decontaminated and decontamination of materials when possible.

Though the population of uninsured black residents is much smaller than before the storm, a new Latino and largely uninsured population is moving in to find jobs in the

reconstruction of the city (Fletcher et al. 2006). Forty-five percent of construction workers in New Orleans at the time of the Fletcher study were Latino, and 54 percent of that community was undocumented.

Workers involved in remediation and reconstruction have a higher risk of mold exposure than the general population returning to the city (Brandt et al. 2006).

According to the *Morbidity and Mortality Weekly Report*, inhalation is the most critical mechanism of exposure to mold in a dampness-affected indoor environment. Most mold spores have a size in the range that allows the particles to deposit in the upper and lower respiratory tracts of the human body. Mold can be aerosolized when people disturb contaminated materials. Such disturbance frequently occurs during the remediation process following a flood. Even dead, nontoxic mold can provoke allergic reactions.

Molds in indoor environments can use wood, wallboard, wallpaper, upholstery and dust as nutrient sources (Brandt et al. 2006). Disrupting these materials through inspection, removal or ventilation exposes workers to toxins, spores or other fungal fragments. At the time of the Fletcher (2006) survey, 16 percent of construction workers were involved in gutting houses, and such workers frequently reported cold/flu symptoms or a cough. Among the group of construction workers who reported health problems, only 27 percent had tried to access health care.

For even small jobs, such as removing contaminated wallboard panels, the Centers for Disease Control and Prevention (CDC) has published guidelines requiring the use of disposable respirators, gloves and eye protection (Brandt et al. 2006). Nineteen percent of construction workers do not have protective equipment at all (Fletcher et al. 2006). Undocumented workers are less likely to have protective equipment than

documented workers. At the time of the Fletcher survey, only 16 percent of workers had all three pieces of equipment.

Long-term health effects of the storm

An important consideration in the future of New Orleans health care is the city's changing demographics (Lambrew and Shalala 2006). Rudowitz, Rowland and Shartzer (2006) predicted that New Orleans will have a smaller, more diverse population in the future. Fletcher and others (2006) found that documented workers have a higher chance of staying than undocumented workers, that almost half of the documented workers intend to stay permanently, and that undocumented workers tended to express intent to stay at least as long as they could find work. There is a gap in public health research on the particular vulnerabilities of migrant workers who arrive in disaster-affected areas, but Fletcher and others argue that, historically, natural disasters affect the poor most severely.

The evidence suggests that undocumented Latino construction workers are more vulnerable to adverse health effects of Hurricane Katrina than other individuals in the city. Reasons include the dangerous conditions in which undocumented immigrants tend to work, their decreased chance of having appropriate protective equipment, and their decreased likelihood of having insurance and access to health care. Fletcher and others wrote that “continued lack of attention to this growing undocumented population could result in an underclass of exploited workers.” (Fletcher et al. 2006, 27)

The authors pointed out that the legal status of a person does not justify the deprivation of health and safety protections. “We cannot have it both ways. Either we enforce immigration laws effectively and prevent illegal immigrants from working or we

allow them to work and provide them with the same labor, safety, and health protections afforded documented workers.” (Fletcher et al. 2006, 27) The authors recognized these disparities as a warning sign for adverse health outcomes in the future. They recommended education about the health risks associated with remediation work, increased availability of safety equipment and increased access to health services for all workers.

Providers and administrators in New Orleans have recommended that the extent of mold contamination and other indoor hazards be monitored and that returning residents not be exposed to hazardous compounds from Katrina floodwater (Greater New Orleans Health Planning Group 2005). The CDC recommended building a new public health strategy for health surveillance among people returning to the flood-affected areas, in order to monitor health effects of exposure to mold (Brandt et al. 2006).

Some of the health effects of Hurricane Katrina will be difficult to diagnose. Mold-related conditions, in particular, can develop over the course of months or years (Greater New Orleans Health Planning Group 2005). Brandt et al. (2006) wrote that making predictions on the health-related effects of mold exposure for any particular worker is an impossible task. Such predictive methods simply haven’t been developed yet. Researchers do know that immunocompromised individuals are more vulnerable to mold-related infections than immunocompetent individuals. However, mold exposure itself can sensitize individuals to allergies, increasing vulnerability to exposure during subsequent mold exposures, especially if the mold in question produces immunosuppressive toxins.

Mold exposure-induced illnesses can manifest themselves in many ways. Conditions can be localized to a certain organ or distributed throughout the body; symptoms can develop in the immediate aftermath of the storm or over a long period of time and can be infectious or non-infectious. For these reasons, providers can face difficulties in diagnosing conditions (Brandt et al. 2006).

Organic dust toxic syndrome (ODTS) is a form of inhalation fever that manifests itself in influenza-like symptoms, and is thought to be caused by exposure to materials with intense microbial contamination. The CDC recommended that the public health system monitor the health of workers who enter, remediate, rehabilitate or destroy flood-affected buildings. Without focused surveillance, diseases such as ODTS could develop and go unrecognized in Katrina-affected communities.

Rebuilding Infrastructure, Eliminating Disparities

The Louisiana Public Health Institute, a planning group that includes the New Orleans Health Department and the academic medical centers, recommended that the regional health care system increase flexibility and awareness. In its report “Framework for a Healthier New Orleans,” the Institute recommended that policymakers base public health decisions on continuous demographic analyses; that primary care be neighborhood-based and that clinics be equipped with current diagnostic technology; that focused health studies monitor levels of exposure to molds and other indoor allergens; that non-emergent visits to emergency departments be eliminated; and that oversight mechanisms and separate workgroups be built into the system to make sure that low-income and uninsured individuals are granted access to long-term quality primary care,

including comprehensive disease management for chronic conditions like asthma and depression (Greater New Orleans Health Planning Group 2005).

Several researchers argued that continuous monitoring of working conditions, chronic storm-related health effects and demographic trends should be rigorous in order to adapt health policy appropriately during the recovery process (Rudowitz, Rowland, and Shartzter 2006; Greater New Orleans Health Planning Group 2005). If city and state leaders rebuild the system as it was before Hurricane Katrina, the state's deplorable health statistics will also return.

In a JAMA commentary, public health researchers Lambrew and Shalala (2006) argued that flexibility and reform are critical. They recommended continued and adequate funding of the health infrastructure. Rebuilding a diminished health care system will cost more, they wrote, than starting with a system bolstered with federal funding throughout the transition. This recommendation is consistent with the CDC's recommendation for continuing support for rebuilding Katrina-affected health care infrastructure throughout the reconstruction phase (Public health response 2006).

Summary

As of January 2007, Charity Hospital's pre-Katrina facility is still closed, and health care sources for the indigent and uninsured are severely limited. The Charity Trauma Center opened up on Apr. 24, 2006, at Elmwood Hospital (Rudowitz, Rowland and Shartzter 2006), and the hospital's emergency department has moved from an abandoned storefront near the old facility to the current University Hospital. According to the Memorandum of Understanding negotiated by the Department of Veterans Affairs

and LSU, those two parties will work together to develop and operate replacement hospitals in New Orleans. This partnership may result in a replacement facility for Charity Hospital (Rudowitz, Rowland, and Shartzler 2006).

Pointing to the fact that around one third of Americans are uninsured or underinsured, Lambrew and Shalala (2006) argued that the health care problems post-Katrina are symptoms of the nation's larger health care systemic issues; that they were created by pre-existing health policy (not by the storm itself); and that leaders should try to make health care accessible and affordable and to eliminate disparities in quality throughout the rebuilding process.

Several health care and policy leaders considered the storm a potential precursor to beneficial and comprehensive reform. The Louisiana Public Health Institute called it "the opportunity of disaster" (Greater New Orleans Health Planning Group 2005, 8). One former American Medical Association leader wrote "the fact that such a massive disruption to a long-recognized failed health care system provided a wonderful opportunity to turn lemons into lemonade." (Ellis 2006, 22)

Hurricane Katrina was not only a community disaster, but it was also a personal tragedy for many families. Referring to the storm with the language of "lemonade" and "wonderful opportunity" could be viewed as insensitive, if not for three factors. First, Louisiana needed comprehensive health reform even before the storm occurred. Several analysts argue that New Orleans' health care system was already broken, and that Hurricane Katrina only made the gaps more visible (Lambrew and Shalala 2006; Zigmond 2006)

Second, as Oberlander (2003) wrote, comprehensive reform can only be accomplished in response to crises. The subject of expanded or universal health coverage is too divisive and poses too much disruption to powerful interests to be tackled in the institutionally fragmented arena of normal policymaking. Only in crises can all the necessary constituents come together.

The third reason that such an optimistic statement should neither evoke offense nor be dismissed is that state health systems can operate as laboratories for the sort of comprehensive national reform that raises quality and lowers access barriers for health care consumers nationwide (Oliver and Paul-Shaheen 1997). New Orleans is an even more likely laboratory for change, since the city will be a major focus for the Democratic Party during the upcoming election. For these reasons, I argue that Louisiana has arrived at an opportunity that policymakers have needed.

The variables of chronic disease, health coverage, and race are indicators of the efficacy of a city's health care system, particularly in a city with such a diverse population, such a high rate of premature mortality and such widespread non-traditional employment. New Orleans must monitor health care needs among residents. Otherwise, underserved patients will overcrowd the emergency departments again.

CHAPTER III: METHODOLOGY

This thesis draws upon a wide range of interdisciplinary sources, from epidemiologic literature to political commentary. This choice was appropriate given the journalistic nature of my thesis and the rapidly evolving state of affairs in Louisiana. All citations follow the author-date system described in *The Chicago Manual of Style*. All text follows *The Associated Press Stylebook*, with very few exceptions.

Some exceptions arise from the need for clarification. For example, *The AP Stylebook* warns under the “abbreviations and acronyms” entry not to follow an entity’s full name with its acronym in parentheses. The length and complexity of the work to follow, however, necessitates the use of this device. Italicization of the text is also used, though *The AP Stylebook* does not make this suggestion, in the interest of clarifying which proper nouns are also composition titles, foreign words and occasionally for emphasis. And although the AP style does not place commas before the “and” in a series, the Chicago author-date citation style does. Therefore this thesis uses the final comma only for the in-text author-date citation of works with multiple authors. Finally, although the author-date citation system does not allow bibliographic entries with no corresponding in-text citation, the committee members have requested an explanation of the media sources that helped to inform the development. Therefore, I have included a non-bibliographic addendum in the Bibliography in order to describe a representative sample of media sources.

The literature review deals with the New Orleans health care system analyzed from three perspectives: the system's capacity to manage chronic disease, the system's accessibility and the system's ability to respond to demographic shifts in the population. Those factors were chosen on the basis of three assumptions. First, a health care system's ability to prevent premature mortality resulting from manageable, long-term conditions like hypertension indicates how well that system provides all of its citizens with continuous access to primary care. Second, the rate of insurance coverage within a given population also greatly influences health outcomes. And third, a health care system's ability to respond to population shifts, particularly the immigration of new ethnic groups, is an indicator of that system's capacity to deliver quality care to all its members.

These three factors provide an axis on which this paper plots the New Orleans public health care system. The content of the articles follows from conclusions reached in the literature review.

Medium

The main body of this thesis is three articles written in the style of *The Times-Picayune*, the major daily newspaper in New Orleans. The potential audience is assumed to be the *Times-Picayune* readership. For this reason, the articles do not include regional or institutional details that the average *Times-Picayune* reader would not need.

Outline

The first article takes a broad look at the reforms needed before the storm and how the storm has affected the potential for reform. In addition this article assesses the capacity of the current system to deliver the health care needs of the community. The article looks at issues of overall health infrastructure and workforce, as well as the personal cost borne by the low-income population of New Orleans in the absence of Charity Hospital. The article will review the debate surrounding the hospital's re-opening, through interviews with policymakers like Louisiana Senator Tom Schedler and administrators like Medical Center of Louisiana Medical Director Cathi Fontenot and EXCELth health care network CEO Micheal Andry.

The second article profiles Father James "Jim" Deshotels, a Jesuit priest and nurse practitioner. He works at the New Orleans Musician Clinic, the Common Ground Latino Health Outreach Project Clinic and other community-based clinics. Father Jim has five master's degrees and work experience in the General Surgery Department in Charity Hospital. The physical and emotional burden of his job makes him an incredibly interesting interview subject. The article focuses on how his clinic targets low-income populations, particularly those individuals who are at risk for health effects through work in flood-affected areas, and the role of the safety-net system in preventing future chronic disease. The article draws upon research from the literature review and interviews with patients throughout the system.

The third article profiles Leah Hodges, a documentary filmmaker, law student and emerging community leader. She has been playing Jamaican music in French Quarter venues since she was a teenager. Now an adult struggling with high blood pressure,

Hodges uses her legal expertise to help others navigate the process of Katrina-related housing assistance. Hodges has no health coverage and no steady income. She's an articulate and passionate interview subject. She can speak firsthand about the health care barriers facing low-income members of a racial minority in New Orleans. The article will use research from the literature review, as well as interviews with providers and policymakers, to elaborate on the broader issues surrounding Hodges' story.

Expert Resources

Most of the human sources for the articles live in or around New Orleans. Interviews were conducted by phone and during two trips to the city, in December 2006 and March 2007. Scholarship funds were used to pay for transportation.

CHAPTER IV: BIG AND LITTLE CHARITY

A year and a half after Hurricane Katrina, the medical center that had carried most of the burden of providing care to non-paying patients in New Orleans remains closed. In Charity Hospital, only a few lights and part of the heating system are turned on to protect temperature-sensitive equipment that remains.

New Orleans faces a health care crisis. According to the 2006 Louisiana Health and Population Survey, more than 20 percent of Jefferson and Plaquemines Parish residents lost health coverage after Katrina. Nearly 30 percent lost coverage in both St. Bernard and Orleans Parishes.

State legislator Tom Schedler, leader of the Senate Republican delegation, is optimistic. “In the post-Katrina era that closed Charity Hospital, to me this is the golden opportunity of disaster,” Schedler says. He says he would like to see the former Charity’s funding dispersed to other community providers, including community clinics and private hospitals.

Schedler points out that Charity’s patients are already going to other doctors. “Why not just leave it like that,” he asks, “and solve the problem of reimbursement?” For alternate providers to receive reimbursement from the federal-state Medicaid pool, Louisiana legislators would need to approve a new payment system. The system must allow providers to track their share of non-paying patients and receive an appropriate share of public funds.

Schedler calls his plan a “dollar follow the patient” plan, but is it really what the doctor ordered? As Louisiana approaches the April 30 opening of its legislative session, no one agrees on how to answer that question.

A history of poverty

New Orleans’ “safety net” system has always struggled financially. From Charity Hospital’s beginnings more than 250 years ago, New Orleans residents have had a two-tiered health care system. According to a commentary from October 2006 by the Public Affairs Research Council of Louisiana, there were “one tier for the population with health coverage that allows wide choice of providers and services and another tier for the uninsured that forces them to rely almost solely on the charity hospital system.”

Southeast Louisiana, and particularly New Orleans, actually had several “charity” systems. “Big Charity,” the Medical Center of Louisiana system, includes the LSU Health care Network, the previous Charity Hospital facility, University Hospital and five other Louisiana hospitals. Yet the Center is only one of the groups that provide health care services to the city’s low-income and medically needy residents. Most places do not provide care free of charge.

Of all these providers, Charity Hospital has traditionally carried most of the burden. By 2005, Charity Hospital alone accounted for more than 80 percent of both inpatient and outpatient costs for uninsured patients in New Orleans. The occupancy rate for inpatient beds at Charity was much higher than the average occupancy rate elsewhere in the city. Although the hospital’s funding source and location have changed several

times since it first opened its doors, for more than 250 years Charity Hospital has been the main source of care for New Orleans residents who can't afford to pay.

The hospital's first funding source was Jean Louis, a French sailor and boat-builder who had seen the military hospital turn away indigent patients. Upon his death in 1736, Louis' gift of 10,000 French *livres* established a hospital to serve the city's poorest communities.

John Salvaggio wrote in his book *New Orleans' Charity Hospital: A Story of Physicians, Politics, and Poverty* that the hospital was founded "under conditions of desperate need" and survived solely, at first, on private donations. Over the years, Charity has passed from the hands of French widows to Spanish councils, always funded by multiple payers, but never funded sufficiently.

In the early 20th century, Governor Huey Long expanded the Charity system and founded the Louisiana State University (LSU) Medical School. The Medical Center of Louisiana (MCL) now operates both Charity Hospital and LSU's Medical School. This system also includes University Hospital, where Charity's emergency department has reopened.

Cathi Fontenot, medical director of MCL, agrees that the two-tiered system is obsolete. "I think the public hospital system is far from ideal," she says. "I think we need to find an evolving process to get to where we want to be, which is universal coverage."

Fontenot says she doesn't believe, however, that the clinics can fulfill the community's health care needs. "There are lots of do-gooder organizations that are doing

their best to provide care,” Fontenot says. “The problem is that it’s just a drop in the bucket.”

Only MCL, Fontenot says, provides care to certain populations, like federal prisoners and trauma victims. According to commentary by the Public Affairs Research Council, a research organization that endorses the dollar-follow-the-patient plan, implementing the reform would lead to “the downsizing of the charity hospital system.”

Meeting needs in each neighborhood

Father James Deshotels, a nurse practitioner who works at several community clinics in the greater New Orleans area, says Louisiana’s health care funds would be better spent on primary care, rather than hospitals, if the legislature must choose.

“We know we spend the bulk of health care dollars in the last six weeks of life,” Deshotels says. “The care done at federally qualified health centers is what prevents diabetic amputations before they even happen. We stave off that first heart attack. We stave off that first stroke. We make people’s lives more healthy and fulfilling.”

One of Deshotels’ clinics is a converted Catholic church called Daughters of Charity Health Center-St. Cecelia. The lobby, a boxy addition, leads to a sanctuary that has been converted into an elderly daycare center. “Instead of going to nursing homes they can come here to hang out and get all their care,” he says.

Where the congregation used to sit in pews and observe Sunday Mass, offices for counseling and case management line the walls. Farther back in the nave, where the priest would have prepared the altar for communion, there’s an activity room where elderly patients can eat and hang out.

Behind the old sacristy, there's a garden with a circular brick fountain, concrete ramps with painted guardrails and lots of green plants. The St. Cecelia's staff lets Alzheimers patients into the garden for fresh air. "It's just a lovely place where people can be outside without worrying about walking out in the street and getting hurt," says Deshotels.

The Daughters of Charity Services of New Orleans, a health care funding organization associated with an international health care system and an order of nuns sharing the same name, aims to provide holistic care to the indigent and the working poor. Yet the name confuses some area residents. People assume that the organization is tied to the former Charity Hospital, and that both facilities offer services free of charge.

Yet Charity Hospital and Daughters of Charity are independent entities. Although neither place will turn away patients based on their insurance status, both places charge patients for their services.

The Daughters of Charity Health Center-St. Cecelia opened in August 2006. Several stakeholders, including EXCELth—a non-profit primary care network created in 1991 to establish, manage and fund New Orleans' federally qualified health centers—manage the clinic as a jointed effort. The CEO of EXCELth, Micheal Andry, also sits on the Community Advisory Committee for Charity Hospital. Andry says federally qualified health centers like St. Cecelia's are more flexible than hospitals.

"What it picked up was a model that had been demonstrated in South Africa as a mission," Andry says. "It goes back to having community solutions for things, sort of 'It takes a whole village' kind of thing. Over the years, we've prided ourselves on being open to collaboration."

Federally qualified health centers like St. Cecelia's have a board of 51 percent consumers, in order to help the providers stay in touch with the community needs. Yet St. Cecilia's didn't have an independent board when it opened its doors. Administrators have been recruiting community members and establishing an advisory committee as they go along so the clinic could open more quickly after Hurricane Katrina.

The politics of reconstruction

Prior to Hurricane Katrina, Charity Hospital had consumed a large part of the state's Medicaid funds. Yet Big Charity entered the 21st century in its traditional state of financial strain.

"At every Joint Commission meeting, they said that the facility was dilapidated and falling down around us, which we already knew," says Fontenot. "We were about 18 months into a process to combine the campuses and build a new hospital."

Although she says that Charity's facilities were aging and its model outdated, she says that it served a critical role in the community. "Trauma has always been our forte," says Fontenot, "and that's because we have all the right physicians in-house. We always have an anesthesiologist, trauma, surgeons, blood bank, etc. It could take hours at other hospitals to get the right people together. And a trauma delay sometimes equals death."

In order to house a sophisticated trauma unit in a hospital with few privately insured patients, the MCL turned for funding to a Medicaid program called disproportionate share hospital (DSH) funds. Congress established DSH funding in 1981 and increased state allotments in the program through the Medicare Modernization Act of 2003.

Through the DSH program, the federal government matches state contributions according to a ratio that varies from state to state. The ratio is based on per capita income. In Louisiana, the federal government triples the state's contribution.

DSH funds go only to hospital care, not to community clinics, even if those clinics serve a primarily non-paying population. "The Charity system was pretty greedy," says Trish Olivier, the Community Development Specialist for the Louisiana Primary Care Association, a non-profit organization that has partnered with EXCELth to establish and fund community clinics. "It's a monster. It's huge." Olivier says the state would have benefited from dispersing some of the money in the DSH program to other providers.

"Our entire state is basically a medically underserved area," Olivier says.

Mixed response for a new plan

"There will be a Charity Hospital in New Orleans," Andry says. "The question is what kind will it be? There is a need to redesign Charity Hospital, as well as there is to redesign our health care system."

Sen. Schedler says he has a plan to reimburse providers on a fee-for-service basis with some of the Medicaid money that funded Charity Hospital before the storm. Enrollees would be able to access care wherever they choose.

"It's a drastic deviation," Schedler says, "but it would put us more in line with what other states are doing." He says the Louisiana Health Care Redesign Collaborative—a planning body that includes representatives from the Louisiana

Recovery Authority, EXCELth and the LSU Health Sciences Center—endorses a dollar-follow-the-patient plan.

The plan, Schedler says, would dramatically increase health coverage in the area, but it would not require a complete legislative overhaul. “It’s really more of a system change,” he says, though a bill would be necessary to approve the change in funding policy. “We need to get the federal government to sign off on it because a lot of the funding is federal.”

Schedler has until April, when the Louisiana state legislature season opens, to overcome the major political obstacles. “The barriers are just territorial fights,” he says. “It’s part of a system that’s been around for a long time and that some people benefit substantially from.”

CHAPTER V: THAT LONESOME ROAD

Jesuit Father James “Jim” Deshotels takes a break in the lobby of his medical clinic in Kenner. “We’re a religious order founded by St. Ignatius of Loyola in 1541,” Father Jim says, twisting a soft, black prayer rope in his fingers. “We’ve had a presence in this area for more than 300 years.”

Father Jim has an intense, worried look in his eye. His thick bifocal lenses amplify his eyes to insect-like proportions and set them back from the rest of his face. He is almost legally blind, and he says that helps him to empathize with patients who are physically disabled or socially marginalized.

He says that, over the years, the frustrating reality of treating the poorest patients in New Orleans has really gotten him down. But he insists that his emotional state has improved. “They sent me off to treatment for depression three years ago,” he says. “So I’m not suicidal anymore.”

He attributes some of his emotional problems to what he describes as the “depressing morals” of the healthcare system. “It’s very uplifting when you see people doing well,” he says. “But it’s extremely depressing to tell someone that we don’t have the resources for what you need. You can burn out. It’s hard work, it’s high stress. There’s never enough resources.” He pauses before continuing, “Having said all that, I would not want to be anywhere else.”

Father Jim says racial disparities are a consequence of the way care is delivered to different racial groups. “Some of it’s very subtle,” he says. “Not expecting

people to be compliant, not getting them what they need. It's well-documented that people of color do not get treated to goal for high blood pressure, diabetes, and asthma.”

Until Hurricane Katrina, the Latino population in Louisiana was relatively small. A small wave of Hondurans had immigrated to the area in 1998 after Hurricane Mitch. According to the U.S. Census Bureau, in 2005 the Latino population made up only 2.8 percent of the population in Louisiana—compared to 14.4 percent in the U.S. Since the storm, however, jornaleros, or migrant day laborers, have been coming from other states to find work in the reconstruction of the city.

In March 2006, the University of California-Berkeley’s International Human Rights Law Clinic surveyed New Orleans construction workers in order to investigate human rights issues in the post-Katrina workforce. The Berkeley researchers targeted Latino workers in particular. The study found that 54 percent of the city’s Latino community are undocumented, and thus ineligible for Medicaid.

“Even my [Daughters of Charity] clinic requires a photo ID,” Father Jim says. “If you don’t have a photo ID, they turn you away. This is in order to shelter themselves from Medicaid fraud, so it’s wise, but it’s a practice that denies care.”

More importantly, he says, this policy denies care to the very people who are helping to bring New Orleans back. “This last year has been a killer,” he says. “You have so little to work with. You see people that have so little and such great need. Latinos are doing all this work to help rebuild but have no access to healthcare.”

Cathi Fontenot, medical director of the Medical Center of Louisiana, the hospital system that operated Charity Hospital pre-Katrina, says that this is a misguided policy. “As the illegal immigration population increases, there really simply is no funding,” she

says. “The hospital is obligated to charge all aliens for mammograms. All that does is discourage people from getting elective preventive care, and they end up in your emergency room with breast cancer.”

Charity Hospital, which previously served the city’s indigent population, including undocumented workers, remains closed. After the storm, Charity’s emergency department set up temporarily in the Convention Center, then moved to an abandoned department store, and in the past few months has set up a more traditional operation in University Hospital. Both Charity and University Hospitals are part of the Medical Center of Louisiana, the health network that includes the Louisiana State University system.

Smaller clinics also serve the city’s indigent population. There is a mobile clinic at St. Anna’s Episcopal Church in the Tremé and one at the Hispanic Business Resources and Technology Center in Kenner. There’s a federally qualified health center at St. Cecelia’s Catholic Church in the Bywater. Father Jim works at all three clinics.

He says his goal is to provide primary and preventive care to keep patients from ending up in the hospital. At his Kenner facility, where he takes St. Anna’s medical van each Thursday, he sees a lot of patients with diabetes. Although officially a Latino outreach program, the clinic serves a diverse population of low-income patients. Throughout the day, the stream of visitors includes first-generation Asian immigrants, as well as white Kenner natives.

Minerva Rodriguez, a Latina who doesn’t speak any English, comes up the stairs to meet with the medical assistants. A nursing school volunteer measures Rodriguez’s blood pressure, height and weight and takes a blood sample from the tip of her finger.

“It's only been a week since I've known that I have diabetes,” she says in Spanish. “They tested my blood. Before that, at another small clinic, they told me I didn't have it.”

Rodriguez walks into the examining room at the back of the van. “Your sugar is 250, much better,” says Father Jim. “Are you taking your medications?” She nods.

Father Jim leaves the room for a moment. “I don't know where any other clinics are in this neighborhood,” Rodriguez says. “I know there is one, but I don't have health coverage and I don't have a social security card.” She and her four sisters entered the country illegally several years ago and lived in New Orleans for five of those years.

Father Jim re-enters the examining room. He and Rodriguez talk about medicines and dosage. He says Rodriguez's diabetes is manageable, but she also complains about headaches. She describes the pain to Father Jim, and he tells her about the possible causes. He tells her headaches can result from vision problems, stress or allergies, and New Orleans is a terrible place for people with respiratory sensitivities. “We were the capital of mold even before the storm,” says Father Jim.

Rodriguez says she feels respected at the clinic, and she feels comfortable with the counseling that she receives. “The nutritionist beforehand told me all the information I need about what I can eat and what I can't eat,” she says, adding that it will be easy to make the lifestyle choices to manage her blood sugar.

Like most of his Latino patients, Father Jim is not a native New Orleanian. He graduated from a Jesuit high school in Milwaukee. “I had been raised to be angry at injustice and angry at unnecessary pain,” he says. “Depression is nothing but anger turned inwards.”

Father Jim's first experience with hospital care came during the 1980s, when he worked six months in one of the most intense wards at "Big Charity." "General Surgery was called the 'Knife and Gun Club' because you could walk around the beds and say 'Knife wound, gun wound, knife wound,' and get seven out of 10 right," he says.

Father Jim says Charity Hospital fills a gap for which the private health care sector has no interest. "I remember people coming to us at Big Charity, saying 'You know this place is such a zoo but at least I feel respected.'" He says, with a laugh, "Of course they had to bring their own washrag." Father Jim could never fully decide between health care and ministry. The Jesuit order encourages scholarly work, so he followed nursing school with four more master's degrees: two in theology, one in philosophy and another in public health.

"I have five master's degrees and I actually use four of them regularly," he says. "Occasionally people will suggest that I go back and get a Ph.D. and I say 'Hell no.' I don't want to be a paper chaser." He thinks for a second, twisting the black yarn of his prayer rope, and adds, "I'm not going to change the way health care's done in New Orleans by teaching nursing."

Limitations and constraints

Since the storm, Father Jim has taken a position where he is supposed to do full-time outreach. But he says he had no mobile medical unit to go to the neighborhoods that needed care the most. Meanwhile, St. Anna's did have a mobile unit, but no staff. So he approached them about forming a partnership, and now he puts in hours at both programs.

St. Anna's bought the used mobile clinic and repainted it. You can still make out the words of the previous owners under the current paint job. "And for all that you've really got to give it credit for working pretty well," he says. The mobile unit houses two tiny examining rooms, one at the front and one in the rear. Three miniature refrigerators hold specimens, medications, and food separately.

Unlike the Daughters of Charity clinic at St. Cecelia's, St. Anna's doesn't have any clinical space. So Father Jim takes the mobile clinic there on Mondays. On Wednesdays the van goes to Southern University at New Orleans, where someone else staffs it.

Partnerships are common among the smaller health care organizations in New Orleans. The community clinics' model is the antithesis of the Medical Center of Louisiana, the highly centralized system which formerly included both University and Charity Hospitals. The clinics work together as a network of funders and providers, none of whom could provide the full complement of vital services by themselves. Each clinic targets the neighborhood that they serve, yet several agencies may manage the effort.

Father Jim says this business model is a challenge in itself. "People aren't used to working with multiple partners from multiple agencies as if we were one agency," he says. "And that's what we were supposed to do."

The hard part comes when patients need specialty services or have a combination of chronic conditions. "I see a lot of people who have had diabetes for a long time and have lost their doctors," Father Jim says, adding that the issue of chronic disease is compounded further when a diabetic patient also shows symptoms of other serious illnesses, such as hypertension or depression. "A lot of people are on blood pressure

medication, but they need to be on a combination, for blood pressure and diabetes as well.”

Tough decisions

Father Jim doesn't have resources to prevent some of the most preventable illnesses in the New Orleans community. He can't hand out respirators and gloves to all remediation workers that he sees. “It was common to see after the storm the white foreman with protective mask and goggles and the Hispanic workers working bare-faced and bare-chested,” he says. “And of course they're all smoking. They're all working in the dirt.”

Nor can he prescribe many smokers a cigarette cessation aid. The products can cost \$50 or more without health insurance. Jim says this combination of toxic work environments, unhealthful behaviors and lack of primary care has led to a high prevalence of respiratory infections among New Orleans' relatively new population of Latino workers.

“Most of what you get with the mold is you get irritation,” he says, “and you get people getting lung infections on top of that irritation.” The Centers for Disease Control and Prevention say that even people with high-functioning immune systems can develop reactive infections that they wouldn't otherwise have if they are repeatedly exposed to mold or some other type of environmental contamination.

An added problem is that the Latino immigrant community is much less likely to be insured than New Orleans natives. According to a post-Katrina construction worker survey conducted by Berkeley's International Human Rights Law Clinic, 54 percent of

the workers were undocumented Latinos, and less than 9 percent of the undocumented workers had health insurance.

For New Orleans' uninsured workers, particularly those who are working in the city without the entitlements of citizenship, smaller community clinics may provide the only primary care. The only other option is the University Hospital Emergency Department. Yet community clinics, relative to public hospitals, receive sparse funding from the Louisiana legislature.

Father Jim says everyone should get basics like check-ups, nutritional counseling and case management. He argues that health care is a human right, not a condition of American citizenship. So every Friday he takes the Episcopal Diocese's mobile unit—which is slightly more spacious than the Daughters of Charity unit, but with only one examining room—to Kenner, where Louisiana's Latino community is concentrated.

“One of the challenges is that this population is illegal,” he says, “or they're legal but not eligible for Medicaid, or it's hard to access services.” Illegal immigrants are ineligible for all but emergency Medicaid coverage. Father Jim says that underserved patients, whether American citizens or not, end up in the emergency department when their conditions are not diagnosed and properly managed. Medicaid foots the bill in the end, allocating a large part of Louisiana's state and federal Medicaid budget to reimburse hospitals.

According to a report prepared by health care policy analysts at the Henry J. Kaiser Family Foundation, in 2004 Louisiana ranked fourth in the nation for its high rate of emergency department use.

Father Jim doesn't have much faith in reformers' efforts. He says the old system, even though currently out-of-order, is too entrenched in Louisiana politics to change.

Thank goodness it's Wednesday

Each Wednesday night, however, a gathering of volunteers and music enthusiasts can see a slightly more hopeful Father Jim. Those are the nights that he attends to walk-in patients at the New Orleans Musician's Clinic fund-raising dinners.

He moves through the crowd in the kitchen of St. Anna's Episcopal Church with a stethoscope around his neck. A band plays upbeat jazz music in an alcove formed by the wide hallway that leads to the bathrooms. A white plaster statuette of Jesus hangs on the red, painted brick of the hallway behind the band. Folding tables and chairs provide communal dinner seating for supporters packed from one wall to another.

An older man with an infection from a yard-raking injury shows the priest his hands. They talk over the music for a few minutes, and Father Jim suggests a regimen of antibiotics and a method for wrapping the injured hand. He also recommends that his patient wear gloves next time, warning him about tetanus and other soil bacteria.

Then, with a much-needed pause in his clinical duties, Father Jim retreats to the relative privacy of an unpartitioned clinical space to fill out his charts. Tomorrow he will work at another clinic in Algiers. He says he wants to catch up on his paperwork. Sounds of applause, scooting chairs, and clanking dishes float in from the kitchen. This is the highlight of Father Jim's week, even if he can only enjoy it from behind a clipboard.

Meanwhile, all but one of the band members are exiting St. Anna's makeshift stage to fill plates of food or consult the visiting acupuncturist. The guitarist, a sandy-haired man dressed in a tweed jacket, sets down his guitar and picks up a banjo. He plucks the instrument and sings.

“People traveling with such a load,

Traveling, traveling, down that lonesome road.”

CHAPTER VI: FADING AWAY FROM HERE

In the front room of a rented house near the French Quarter, two women sit at a tall black table covered with papers. Leah Hodges is advising her friend Sheryl Jones on obtaining the funds to renovate her house through the Louisiana Road Home program.

“Don’t let this work on your blood pressure,” Hodges says. A few years ago, she dropped out of the University of New Orleans Law School with one semester left in order to care for her ailing grandfather. When he passed on, she wanted to return, but her friends warned her to take time to grieve.

“And that’s when the storm blew up,” she says. Now she uses her legal expertise to help others move back into their houses. At the same time that she is stepping into her new role as a legal advocate, she is experiencing headaches and dizziness from her rising blood pressure.

“I felt like my brains were swelling up on me,” she says, remembering a particularly bad episode. “I felt like I was fading away from here.” Symptoms like headaches, confusion and fatigue usually don’t appear until hypertension has reached a dangerous stage, when a patient becomes vulnerable to heart attack and stroke.

The medical community has known for many years that hypertension has both genetic and behavioral causes. Although there are many pharmaceutical options for patients with hypertension, doctors often first prescribe lifestyle changes. This may include diet, exercise, smoking cessation and stress reduction.

A study published earlier this year in the journal *Ethnicity and Disease* puts Hodges in the most vulnerable category for variables beyond her control—those of age, ethnicity and gender. The study, called “Black-White Differences in Age Trajectories of Hypertension Prevalence Among Adult Women and Men,” found a significant disparity between blacks and whites in the prevalence of hypertension. The researchers found that this disparity widens throughout adulthood, and that black women in particular show the most rapid rise of any race/gender category. Their prevalence of hypertension rises dramatically after the age of 40.

Living in the state of Louisiana also stacks the odds against Hodges. According to the Henry J. Kaiser Family Foundation, the mortality rate associated with heart disease is higher in Louisiana among both women and blacks than the national rate for those two groups. The heart disease mortality rate of blacks in Louisiana is higher than the national rate—310.3 black residents per 100,000, as opposed to 308.4 in the U.S. on the whole. The regional disparity is wider for women. Two hundred twenty for every 100,000 women in Louisiana die of heart disease each year, as opposed to 197.1 in the rest of the country.

How we got here

Hodges’ family comes from a melting pot of racial groups. She says most of her father’s ancestors were West African slaves who ran away from a plantation in North Carolina. But rather than heading north, she says they migrated to Louisiana, where they married into an abolitionist Cherokee tribe.

Hodges' father's father immigrated to Louisiana from Trinidad, likely bringing a mixture of South American indigenous, European and Indian blood with him. Hodges grew up hearing and incorporating her grandfather's accent before she even knew he had one. Not until she visited Jamaica in 1995 did anyone tell her that she spoke with a slight West Indian accent herself.

As teenagers, she and her brother played together at Tipitina's and other French Quarter venues with Jamaican groups like the Buffalo Soldiers. "Our family brought reggae music to New Orleans," she says. "People thought we were crazy."

Hodges still plays the piano and the guitar, and she also sings jazz and reggae. Bethany Bultman, co-founder of the New Orleans Musician's Clinic, says those talents are a powerful force in New Orleans, a city famous for its musical heritage. "Early on one of the second goals we had was we wanted to use musicians as cultural icons and thought leaders," Bultman says. She envisioned female musicians telling other women about the importance of mammograms.

Hodges would much rather talk about housing issues than preventive health measures. "Where do I find health care?" Hodges says with a laugh. "Most of the time, I don't."

Bills and blood pressure

Since the storm, Hodges has bounced from one clinic to another in an effort to manage her blood pressure. She received her first diagnosis of hypertension at the Tulane University Emergency Department after Hurricane Katrina.

“The doctor questioned me, examined me, asked me if I had bad blood pressure before,” she says, and the answer was “no.” Her blood pressure at the time, however, was 154 over 98. A normal reading would be less than 120 over 80. The stage known as prehypertension falls within 120-139 over 80-89. Hodges’ Tulane reading falls into the upper reaches of Stage 1 hypertension.

Hodges still receives bills from Tulane that she can’t pay. “And guess what?” she says. “They didn’t even prescribe any medications for my blood pressure. They didn’t even treat me.” Since it was her first diagnosis of hypertension, the doctor suggested that Hodges’ high blood pressure reading might have represented only a temporary spike.

“She bounced me out of that hospital with no medications,” Hodges says, indignant at the memory. She pulls out two bills from the same emergency department visit. “These two appeared in my mailbox in the same day.”

Next, Hodges went to the Louisiana State University (LSU) clinic for her second attempt to get treatment. “They refused to see me unless I give them \$15,” she says. “And once they did serve me, they said they were surprised I didn’t have a stroke.”

The LSU clinic referred her to a specialist whom she doubted that she could afford. Before the appointment with the specialist, she found out about a mobile medical clinic based at St. Anna’s, an Episcopal church that also hosts Wednesday night musician dinners. There, the doctor doubled the dose of her previous prescription.

“So now as long as I don’t get really worked up, I don’t press myself too hard...” her voice trails off into laughter. Meanwhile, she’s got a stack of bills for what she had assumed would be free medical service. The bills have ruined her credit, and for all that she still can’t keep her blood pressure down.

“They’re sending me a bill for physician charges and they didn’t prescribe me anything,” she says. “They did nothing. These people have the money to preserve the gift of life and they simply won’t do it. It is a human rights violation.”

A medical home

Hodges blood pressure is rising again. “My head tells me,” she says. “I have all kinds of pain and pressure in my head.” It’s a sharp, radiating headache that she never had before the storm.

So she makes an appointment at the Tulane University Community Health Center at Covenant House. The clinic is tucked away in a brick building next to Louis Armstrong Park. A couple of LSU students started the clinic after the storm, and now it provides free care to low-income patients. The lobby is crowded, but spacious, with tall ceilings and wide, beige floor tiles.

Danielle Matthews, a young black nurse in blue scrubs, calls Hodges’ into another room to take her blood pressure. “Not outrageous, but high enough to be concerned about,” Matthews says. At 180 over 110, it’s the highest it’s ever been.

“Hypertension is a problem, especially in African-Americans, because we were never told at an early age how to eat right,” Matthews says. “We don’t understand the magnitude of hypertension, how to control it.” She blames the public school system for cutting programs on health education.

“That’s why I think it’s important that here we teach preventive education,” she says. “We teach wellness. There are lots of classes. First thing nutrition, then after a month we start medications.”

In Hodges' case, the doctor doesn't wait a month to give her a new medication, but he does counsel her on nutrition and other lifestyle issues. "[The doctor] is very calming, very assuring," she says. "Those people know how to give a pap smear. It's the first time I didn't scream."

She had a diabetes test and gynecologic check-up, in addition to the blood pressure counseling. "He did prescribe some really good medications," she says. "If they had medicated me when I went to Tulane last year I may not need two medications now."

As she waits on the corner, she reflects on what lies ahead. Hypertension has come at the same time as many other challenges in her life. "I've never had a problem with my blood pressure," she says. "I never thought I'd see the day, from 120 over 70 all my life." With her new medication and some changes in her lifestyle, Hodges says she will continue to work on legal advocacy and perform music.

"God is showing me where I need to be," she says, "and where I need to go."

CONCLUSION

Through interviews with providers, patients and community members, as well as a literature and press review, this thesis takes into account a wide variety of input on the state of the Louisiana health care system. I did not include the experiences of Leah Hodges and Father James Deshotels because I consider them to be typical of New Orleans patients and providers. Rather, these two people's stories should be viewed as representative only in that they struggle with the same larger problem as many New Orleans residents: the low accessibility of health care services in New Orleans.

The health care system must be redesigned to some extent. At the very least the Medical Center of Louisiana must adapt to respond to the demographic shifts and health issues resulting from Hurricane Katrina. The public hospital system, however, has needed reform for years before the storm.

This thesis supports the creation of some form of the dollar-follow-the-patient system. The new payment system would alleviate the burden of uncompensated care at hospitals, increase funding for federally qualified health centers and encourage private hospitals to provide more indigent care. Because community clinics have a simpler infrastructure, they can provide primary care at a lower cost than hospitals. Therefore, reform would go far to solve the under-funding of the health care system. It would also increase the number of health care access points in a state that is largely rural and has a less than ideal public transportation system.

This thesis does not support health care funding policies that tie delivery of care to a patient's citizenship status. Historically, immigrant and minority populations suffered the most in the aftermath of public health disasters like hurricanes. Racial disparities have been documented for years. These issues can only be addressed with a public health system that aggressively monitors the needs of the community.

The United States Constitution does not say that high-quality health care is a human right. However, a healthy and insured population is in the best economic and epidemiologic interest of the community. Therefore, state and federal legislators, health care administrators and providers, and Louisiana citizens should consider the implementation of a new payment system that would bring the state's uninsured residents into the health care system.

This reform would decrease global, long-term health care costs. It would also allow various state and federal agencies to more closely monitor health issues and demographics among New Orleans' indigent and illegal immigrant populations.

This thesis brings up several questions that merit further pursuit. The role of state politics in health care funding in Louisiana is very complex. For example, according to Louisiana legislature financial disclosure forms, state Sen. Joe McPherson, D-Woodworth, has invested in a nursing home. This could represent a conflict of interest, since McPherson has been a vocal opponent of health care reform, and nursing homes receive substantial public financing in Louisiana. Through analysis of financial disclosure forms and interviews with state legislators, a new article would potentially elucidate why partisan lines are so firmly drawn on the issue of health care reform.

Another valuable investigation would focus on illegal immigrants in terms of their role in both New Orleans' economy and reconstruction, as well as the burden this population poses to the health care system. New Orleans residents respond in a variety of ways to this issue. This article could draw from interviews with citizens, illegal aliens, politicians, health care providers and relevant researchers. Race and health are issues that should be reported in comprehensive and respectful terms by the press. As this thesis demonstrates, both issues continue to influence daily life in the American South.

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The thesis was also informed by regional and national media sources not cited directly in the text. The author has continuously monitored the state of Louisiana health care via RSS feeds such as the NOLA.com-based feed for The Times-Picayune. Other valuable news feeds included the Baton Rouge paper The Advocate, New Orleans paper City Business, the New Orleans web logs such as <http://interdictor.livejournal.com/>, Louisiana broadcast news program WWL-TV, and the Archdiocese of New Orleans Department of Internet Services. National newspapers such as The New York Times were also very informative. None of these media, however, were used for quotations or as primary sources, so the Chicago author-date citation system does not require their individual bibliographic entries.